OFFICIAL FILE COPY

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **02 - 06**

2. STATE: **TEXAS**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **December 1, 2002**

5. TYPE OF PLAN MATERIAL *(Circle One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT
a. FFY **2003** ~~$ 1,169,418~~ *See Pen + ink changes
b. FFY **2004** ~~$ 806,833~~

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
SEE ATTACHMENT

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
SEE ATTACHMENT

10. SUBJECT OF AMENDMENT:

This amendment eliminates the homebound requirement for home health services. New language was added to clarify the recipient criteria and to include utilization review components.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Rodger Love

13. TYPED NAME:
Rodger Love

14. TITLE:
Interim State Medicaid Director

15. DATE SUBMITTED:
December 30, 2002

16. RETURN TO:

Rodger Love
Interim State Medicaid Director
Post Office Box 13247
Austin, Texas 78711

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 30 DECEMBER 2002

18. DATE APPROVED: 20 FEBRUARY 2003

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 DECEMBER 2002

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: ANDREW A. FREDRICKSON

22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR
DIV OF MEDICAID AND CHILDREN"S HEALTH

23. REMARKS:
** Pen + Ink Changes: FY 2003 $ 1,210,351
FY 2004 $ 1,239,291

FORM HCFA – 179 (07-92)

Attachment to Block 7 to HCFA Form 179

Transmittal No. TN 02-06, Amendment No. 625

This amendment deletes the language for homebound criteria from the definitions and from the recipient criteria for home health services. New language was added to clarify the recipient criteria for home health services and to include utilization review components. This will result in an increase in expenditures of 3% of the FY 2001 total home health expenditures ($97,941,162) for fee-for-service and Primary Care Case Management clients for FY 2002. Subsequent years have a 2% increase of the new total estimated.

	Total Fiscal Impact	Federal	State
FY2003	$2,017,588	$1,210,351	$807,237
FY2004	$2,057,939	$1,239,291	$818,648
FY2005	$2,099,098	$1,264,077	$835,021

7. Home Health Care Services.

In accordance with the provisions or specifications established by the single state agency, home health care services are as follows:

A. Authorized services, supplies, equipment, or appliances must be suitable for treatment and or related to the medical condition of the recipient. The services provided through home health are intended for the recipient and must be related to the medical condition rather than primarily for the convenience of the recipient, caregiver/guardian, or the provider. The service, supply, equipment, or appliance must be provided to an eligible recipient in his place of residence. The recipient's place of residence does not include a hospital, nursing facility, or intermediate care facility for the mentally retarded. The only exception for services provided in an intermediate care facility for the mentally retarded occurs when the facility is not required to provide services as defined in Subpart I of 42 CFR part 483.

B. The recipient for whom home health care services are authorized must be under the continuing care and supervision of a licensed physician.

   Medical necessity criteria include supporting documentation of the medical need and the appropriateness of the equipment, service, or supply prescribed by the physician for the treatment of the individual recipient.

C. Services, supplies, equipment, or appliances must be prescribed by a physician as medically necessary and appropriate and documented as part of the physician's plan of treatment for the recipient in the written, dated, and signed plan of care and/or order form.

D. All home health benefits require prior authorization for payment, unless otherwise specified by the Title XIX single state agency and must be furnished by a home health agency or a durable medical equipment/supplier enrolled to provide Title XIX home health services. Insulin syringes and needles are obtained with a physician's prescription from a participating pharmacy and do not require prior authorization.

E. To become enrolled as a Title XIX home health agency or home health durable medical equipment supplier, the home health agency or durable medical equipment supplier, must be approved as a Title XVIII (Medicare) home health services provider or durable medical equipment/supplier and must be enrolled with the Title XIX single state agency.

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